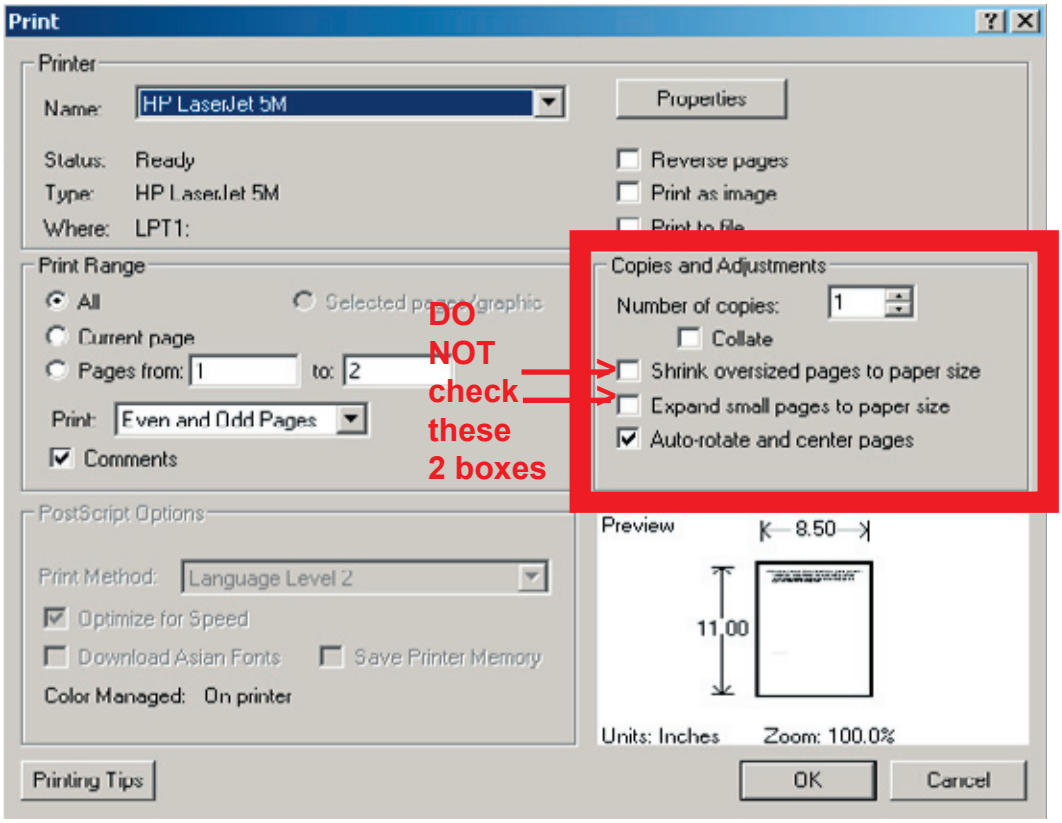
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Denturist License Application Packet

1. 643-007 ... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 643-006 ... Information and Instructions for Denturist Licensure ..... 3 pages
3. 643-001 ... Application for Licensure–Denturist ..... 4 pages
4. 643-005 ... Denturist Verification of Licensure ..... 1 page
4. 643-008 ... Denturists Written Exam Blueprint ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Denturist

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 643-007 (REV 3/2006)

1F 0251080000 01675

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Washington State Department of Health
Board of Denturists
PO Box 1099
Olympia, WA 98504-7868

Denturist Information, Application Instructions, and Checklist

Denturist fees and renewal cycle

Licenses must be renewed every 2 years on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

Fee Schedule for Denturists

Application	$1,000.00
State Examination	1,500.00
Reexamination, written	500.00
Reexamination, practical	500.00
License Renewal	2,750.00
Late Renewal Penalty	300.00
Expired License Reissuance	300.00
Inactive License Renewal	1,500.00
Expired Inactive License Reissuance	300.00
Duplicate License	15.00
Certification of License	25.00
Multiple Location Licenses	50.00

Information and Instructions for Denturist Licensure

The Denturist Written and Practical Examinations are scheduled at least once a year. The number of candidates and availability of exam facility determine the exact dates.

Individuals interested in taking the Washington State Denturist Examination should contact the Denturist Program office at (360) 236-4700 for information regarding the examination schedule and application deadlines.

Initial (original) application form and application fee must be received in the program office sixty (60) days prior to the scheduled examination date. All supporting documents and examination fee must be received thirty (30) days prior to the scheduled examination.

In the event that no applications are received prior to the initial application deadline, no examination will be administered.

Additional information regarding dates and location of the exam will be sent to eligible candidates prior to the exam dates.

Please keep us advised of any address changes.

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Application Instructions for Denturist Licensure

1. Please read all instructions thoroughly, and complete the application in full. An application that is deficient of any documentation will not be considered. If you need additional space to respond to a question, attach separate sheets, indexed to the appropriate question, to the back of the application. To ensure appropriate review, all information should be typed or printed clearly. A resume **cannot** substitute for completion of the application.
2. Be sure to indicate if you are applying for licensure by examination or endorsement by marking the appropriate box:
    a. **Endorsement.** In accordance with RCW 18.30.090 (1a-b), any Denturist licensed to practice Denturism under the statutory provisions of another state, with licensing standards substantially equivalent to Washington State, shall be licensed without examination upon providing the department with the following:
        (1) Proof of successfully passing both a written and clinical examination for Denturism in a state that has substantially equivalent standards as those in Washington State.
        (2) An affidavit from the state agency where the person is licensed or certified, attesting to the fact of the applicant's licensure or certification. The following states have been determined to meet the equivalency standards as set in RCW 18.30.090(1): Oregon and Maine.
    b. **Examination.** There is one category of eligibility for licensure through examination:
        (1) **Education:** RCW 18.30.090(2), provides eligibility for applicants who:
            (a) Document successful completion of formal training with a major course of study in denturism of not less than two years duration at an educational institution recognized by the board; and
            (b) Pass a written and clinical examination approved by the board.

The following educational programs have been recognized by the board: George Brown College, Ontario, Canada; Northern Alberta Institute of Technology, Alberta, Canada; and, Bates Technical College, Tacoma, Washington.

3. If you have had your name changed, enclose certified documents evidencing the change.
4. Photograph requested may be in color or black and white. Sign and date the front of the photograph.
5. If you answer "Yes" to any of the Personal Data questions, you must submit the additional supporting documentation and a letter of explanation for that question, as indicated on the application. A "Yes" response will not necessarily result in application denial, however, failure to honestly respond could be grounds to deny an application. Where specific statutes are indicated, be sure to read the appropriate statute prior to answering the question.

6. Page 1—License Information. List all states in which you now hold or have held a license as a Denturist or other professional license. Forward the "Verification of License" form to each state that you hold or have held a Denturist license, even if it has now expired.
7. Page 3—Education. Request an official copy of your transcripts and have them sent **directly**, to the address printed below, **in a sealed envelope**.
8. Page 3—Practice Information. Include all employment within the practice of Denture Technology.
9. Complete the attestation on Page 3 regarding the requirement for the completion of a minimum of seven hours of AIDS Education and Training.
10. Complete the Affidavit on page 4. Take to a Notary Public for signing and swearing.
11. Submit the total fee with the completed application. Make all checks or money orders payable to the Department of Health. **Note: All Fees Are Non-Refundable.**
12. The completed application, including all supporting documents and fee, is due thirty days prior to the scheduled examination date for which you are applying.
13. When you are approved for the examination, notification of the time and place will be mailed to you, at the last known address, approximately two weeks prior to the examination date.

Please Note: All application and licensure information is subject to public inspection and copying under Washington State public disclosure law. Recent legislative changes allow the applicants and licensees to request their residential address and residential telephone number be exempt from public disclosure. An alternative personal or business address and telephone number must be provided. A written request is required to exempt your personal residence or telephone number.

Documents received in this office prior to receipt of a completed application form will be held in a supporting documents file for six months.

If a completed application is not received in this office within that six month period, the supporting documents in the file will be destroyed and the applicant will be required to resubmit.

For further information or additional assistance regarding the application process, please contact this office.

Mail original application and fee to:

Department of Health
Board of Denturists
P.O. Box 1099
Olympia, WA 98507-1099

For additional information, please contact:

Health Professions Quality Assurance
Board of Denturists
P.O. Box 47867
Olympia, WA 98504-7867

Customer Service Center: (360) 236-4700
Website Address: https://fortress.wa.gov/doh/hpqa1/hps3/Denturist/default.htm

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only
ISSUANCE DATE:
LICENSE NO:

LICENSE #

Application For Denturist License

☐ Licensure by Examination ☐ Licensure by Endorsement of Credentials and Examination

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. **All fees are non-refundable.**

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	___ ___

GENDER	BIRTHDATE (MO/DA/YR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

Have you ever applied for a Washington license before? ☐ Yes ☐ No

If yes, list date(s):

Have you ever been known by any other name? ☐ Yes ☐ No

If yes, list.

HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Previous Licensure

List all states (including Washington) where licenses are or were held. Please provide an affidavit from each jurisdiction where you are/were licensed to practice. Specifically list certifications/licenses/registrations granted by examination, endorsement, or grandfathering.

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE	CURRENTLY IN FORCE
			YR ISSUED	NUMBER		
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training, and attach an official transcript. (Attach additional 8 1/2 X 11 sheet if necessary.)

SCHOOLS ATTENDED FULL NAME, CITY AND STATE	DEGREE EARNED	ATTENDANCE	
		ENTRANCE DATE	ENDING DATE

5. Professional Experience

In chronological order, list all names and addresses of hospitals, denturists, dental laboratories, etc. by whom you were employed and/or self employment location. (Exclude activities listed under other sections.) (Attach additional 8 1/2 X 11 sheet if necessary.)

NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	DUTIES/TITLE	INCLUSIVE DATES OF EXPERIENCE	
		BEGINNING DATE (MO/YR)	ENDING DATE (MO/YR)

6. AIDS Education and Training Attestation

I certify I have completed the minimum of 7 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant _____ Date _____

Signed and sworn before me on _____ by _____
PRINT APPLICANT'S NAME

VOID WITHOUT NOTARY SEAL HERE

Notary Public in and for the state of _____

_____ My appointment expires: _____
NOTARY NAME PRINTED

Official Use Only

Washington State Records Center

Washington State Department of Health
Board of Denturists
PO Box 47867
Olympia, WA 98504-7867

Denturist
Verification of Licensure

To Applicant: Complete top portion in full and forward to the state, province, or country in which you hold or have held a credential as a denturist. There may be a fee for this service.

Name _____ (LAST / FIRST / MIDDLE INITIAL) Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

License Number _____

I authorize the release of the information asked for below to the Washington State Board of Denturists.

Applicant's Signature _____ Date _____

To Certification Authority: The above individual is applying for licensure as a denturist in Washington state. To assist the Board in their review, please complete the following information and return directly to the Board. Thank you for your cooperation.

Name of Licensee _____ (LAST / FIRST / MIDDLE INITIAL)

Date Issued ____ / ____ / ____ License Number _____

Licensed on the basis of (Check all that apply): ☐ Examination ☐ Endorsement ☐ Work Experience

License is currently active with an expiration date of: ____ / ____ / ____

Other Status (inactive, retired, revoked) _____

License not current, expired on: ____ / ____ / ____

Was this the applicant's original license? ☐ Yes ☐ No

If "No", which state or licensing authority is indicated for original licensure? _____

Has there been any disciplinary action initiated or taken against the license? ☐ Yes ☐ No

If yes, please explain: _____

_____

STATE SEAL

_____
SIGNATURE OF VERIFIER

_____
TITLE

_____
STATE BOARD

_____
DATE

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Washington State
Board Of Denturists

Written Examination Blueprint

Head and Oral Anatomy and Psysiology	8.10%
Oral Pathology	20.24%
Partial Denture Construction and Design	12.15%
Microbiology	6.07%
Clinical Dental Technology	20.24%
Dental Laboratory Technology	12.15%
Clinical Jurisprudence	2.83%
Asepsis	10.12%
Cardiopulmonary Resuscitation and Medical Emergencies	4.86%
Nutrition and Pharmacology	2.02%
Geriatrics	1.23%